199 500). Consumption fell from 9·81 litres of pure alcohol per adult to 9·47 litres.[3]

The categorical statement that "as affordability increases so does consumption and vice versa" is simply not true. The figure opposite this statement shows that during 1985-9 affordability increased sharply while consumption levelled off and then fell.

Anderson is rather scornful of current education campaigns that focus on sensible drinking because they may be counterproductive to his favoured population approach, which seems to entail elements of compulsion. In the *Health of the Nation* the government accepts that, in the end, people cannot be coerced into good health and that imposed strategies are valueless. The key seems to be education and not coercion that is based on flawed statistics and statistical reasoning.

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AUTHOR'S REPLY,—Communities with increasing aggregate levels of alcohol consumption tend to support increasing numbers of heavy drinkers and so increasing numbers of people with alcohol problems. This is a consistent finding across countries and over time and has been well reviewed and reported nationally and internationally.[1-3]

A persistent finding over time and across countries is that the most important determinant of alcohol consumption is affordability.[1,2,4] The relative stability of alcohol consumption in a period of increased affordability over the past five years in the United Kingdom does not refute this but argues for the effectiveness of health education programmes.

The relation between availability of alcohol and its consumption has been reviewed and confirmed by work by the Addiction Research Centre in York funded by the Economic and Social Research Council.[4]

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Zidovudine after occupational exposure to HIV

SIR,—I read D J Jeffries's editorial,[1] on prophylaxis with zidovudine after occupational exposure to HIV, and the following correspondence[2,3] with mixed feelings. Colleagues in Western countries are occasionally exposed to a patient in a so called high risk group. In our part of the world, however, we are all at high risk, doctors and patients alike.

I estimate—on good grounds—that 30% of my patients are HIV positive. I do over 100 operations a month, and from my personal experience I agree with A G Bird and colleagues that percutaneous injuries occur in about 15% of operations not counting occasions when patients' blood comes into contact with skin or splashes the eye without injury and disregarding the fact that we often operate while wearing used, resterilised gloves. On the basis of these figures I injure myself on average 4·5 times each month while operating on patients infected with HIV and would therefore be taking zidovudine continuously for the rest of my working life, if I followed Jeffries's recommendations. This would apply to all doctors, midwives, and surgeons in our part of Africa.

Zidovudine is not available in Kampala, but, even if it was, the side effects, dangers, and high cost of its long term use make the discussion about giving it after occupational exposure quite irrelevant and unrealistic in our situation.

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Coronary heart disease and elderly people

SIR,—Robert Beaglehole comments on the lack of evidence justifying the treatment of risk factors for cardiovascular disease in elderly people.[1] We have recently noted both an increasing number of inquiries from general practitioners about the justification for treating hyperlipidaemia in elderly people and an increased number of referrals of elderly patients with hyperlipidaemia to our lipid clinic.

The referral of two fit, slim, normotensive, and non-smoking women in their 70s with no family history of ischaemic heart disease prompted an inquiry into recent requests for estimations of cholesterol concentration made to our biochemistry department by general practitioners (table). This indicated that between the first six months of 1989 and 1991 requests had risen fourfold in patients aged under 65 and sixfold in patients aged 65 and over. The requests comprised 14·4% of all requests by general practitioners in the first half of 1991. Requests by hospitals remained static over this period. Requests from general practitioners arise mainly from the well person or lifestyle clinics that have flourished since the new general practitioner contract was introduced in 1990.

As Beaglehole comments, no clinical trials have assessed the efficacy of lipid lowering regimens in reducing cardiovascular morbidity or mortality in elderly people, and extrapolations from trials conducted in middle aged men may be unjustified.[2] Vigorous treatment of hyperlipidaemia is certainly indicated in younger subjects at high risk, but lack of evidence that treatment reduces total mortality and some concern that non-cardiovascular mortality may be increased[3] reinforce the case for a conservative approach to lipid lowering regimens in patients aged over 65.

Number of requests for serum cholesterol estimations to biochemistry department of Stobhill General Hospital, 1989-91

Age (years)	1989 Months 1-6	1989 Months 7-12	1990 Months 1-6	1990 Months 7-12	1991 Months 1-6
Requests from general practitioners					
16-	1307	1761	3046	4318	5231
65-	125	173	377	582	724
≥75	10	23	72	120	160
Requests from hospitals					
16-	2031	1922	2007	1977	2238
65-	281	293	318	266	361
≥75	64	76	44	65	59

Current guidelines do not state that systematic screening for hyperlipidaemia should *not* be carried out in elderly people,[4,5] perhaps on the grounds that a lipid lowering diet may do some good and cannot do harm. This ignores the anxiety and strain on limited budgets that may follow advice to modify lifelong dietary patterns. Several elderly patients with hyperlipidaemia referred to our lipid clinic have been upset by prior advice to follow a lipid lowering diet. They were delighted to be told to ignore their serum cholesterol concentration and resume their previous dietary pattern, which arrival at pensionable age might indicate had served them well.

Perhaps a citizen's charter for elderly people should guarantee that arrival at pensionable age (and certainly at age 70) provides immunity from lipid screening and lipid lowering diets and drugs. Immunity should remain in force until new evidence indicates that the introduction of lipid lowering regimens produces tangible benefits in old age.

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Use of thalidomide in leprosy

SIR,—The use of thalidomide in the treatment of erythema nodosum leprosum has been discussed.[1-3] There is no doubt that such treatment is effective; but there is also no doubt that the side effects of thalidomide, particularly induced polyneuritis and teratogenicity (allergic vasculitis, thrombocytopenic purpura, and myxoedema have also been reported, and in animals toxicity depends on both the species and the sex[4]), are also of great concern to clinicians and others working with people with leprosy, particularly in developing countries. The lack of control over such a potentially dangerous drug both in clinics and when it is released to patients and the possible misuse of the drug for its known sedative properties are among the reasons for such concern.

The risk-benefit analysis of M F R Waters[5] would provide sufficient justification for using thalidomide if that was the only option for treatment. Though this may be the case now, important advances have been made in developing more suitable alternative compounds. The work of O'Sullivan is particularly important and is well known to those concerned in the chemotherapy of leprosy. He has prepared analogues of clofazimine that do not cause extensive pigmentation, have much improved pharmacokinetic properties, are active against drug resistant organisms, and retain, in some cases, anti-inflammatory properties.[5-7] The development of these compounds should be a priority of the world community, but sadly this is not the case because leprosy is regarded as an orphan disease.

Clofazimine and its analogues, however, have potential in the treatment of other diseases that

are also of great importance. These include other tropical diseases such as leishmaniasis[8]; autoimmune diseases, particularly rheumatoid arthritis[9]; some forms of cancer[10]; and pathogenic and opportunistic mycobacterial infections, especially in patients with AIDS.[11] Political and narrowly defined economic factors, rather than world health, seem to be the determining factors in the development of drugs, allowing orphan drugs and diseases to be glibly dismissed owing to failure of will by the world community.

The possibility of developing new compounds from thalidomide that are much more selectively active than the parent molecule has also not been exhausted.[4] I believe that it is necessary for all concerned with global health to press for such development.

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Seafarers and HIV infection

SIR,—J Dhar and D J Timmins's conclusion that seafarers need to be the target of information on health and on preventing HIV infection[1] cannot be faulted, especially as globally seafarers acquire sexually transmitted diseases (mostly gonorrhoea) 5-20 times more frequently than the male population living on land.[2] But the reference to heterosexual contacts in Madagascar as "representing a long term pool of infection" is puzzling as published reports show a very low seroprevalence of HIV antibodies in that country. In a nationwide survey of more than 12 000 people in 1989 only five cases (0·04%) of HIV infection were detected (A J Rasamindrahotokra *et al*, sixth international conference on AIDS, San Francisco, 1990).

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SIR,—J Dhar and D J Timmins were right to draw attention to the special problem of HIV infection in seafarers. They mentioned a study of 2600 Belgian seafarers, of whom 4·5% were HIV positive, but most of these seafarers were from the African continent, where HIV infection is rife.

The Department of Transport held seminars on AIDS for the Merchant Navy at the Royal College of Physicians of London in 1989 and 1990 with strong support from the Department of Health, the Health Education Authority, and both sides of the shipping industry. British seafarers have been sent a range of pamphlets on the subject, and shipping companies have been urged to provide durable condoms for all crews. The Health Education Authority is funding a multilingual AIDS education package, including a video dedicated to seafarers. It is being developed by the British Red Cross and is currently being field tested and is expected to be launched early next year. The World Health Organisation and the International Labour Office are both showing interest in it, and I hope that, through their help, it will be distributed to all seafarers worldwide.

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Detention of British citizens as hostages in the Gulf

SIR,—J A Easton and S W Turner's article on the health, psychological, and family consequences of being a British hostage in the Gulf war was an insult to women. They report that one of the traumatic events suffered by the hostages was that "several men were forced to watch their wives being raped."[1] Of course the witnessing of such an event will have been traumatic, but how much greater the trauma for the women, yet their trauma goes unmentioned.

Society habitually sees events through male eyes, but such a partisan view fails us. Attitudes among doctors must be changed so that they will no longer tolerate material that treats women as inferior and, in this instance, as unfeeling chattels. The *BMJ* has a responsibility to help engineer such change. To ignore sexism is to collude with it, and that is no longer acceptable.

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Animal experimentation

SIR,—As a member of executive of the Research for Health Charity Group I would like to respond to the singularly uninformed letter from Donal Crawford on animal experimentation.[1]

Fortunately most doctors know the history of penicillin: that the original observation was made by Fleming on a bacteriological culture plate is of course true,[2] but to try to pretend that this was all it took is part of the misinformation which is the animal rights activists' stock in trade and which the Research for Health Charity Group was formed to contest. Most people will know that the purification and development of penicillin for clinical use was carried out by Florey, Chain, and colleagues in Oxford. Animals were used extensively in this process—the protection penicillin gave to mice injected with streptococci is graphically described and this portion of the work was as important, if not more so, than the original observations.[3]

As for the effect of penicillin on guinea pigs, even with the impure preparations available in 1943 Hamre *et al* concluded that, "When treated with the same doses of penicillin per kg as that given to man, guinea pigs did not die" and, in fact, showed no signs of toxicity.[4] Modern crystalline penicillins are even less toxic, showing a sixfold reduction even at these high doses. In fact, penicillin itself is not toxic to guinea pigs, although they have been shown to get a form of colitis similar to pseudomembranous colitis in humans; colitis in both humans and guinea pigs is due to disturbance of intestinal flora, a further indication of the relevance of animal models.

It is curious that the animal rights organisations have to resort to such misrepresentation to prove their point. Such tactics might work with the general public, which is why the medical profession should be aware of and attempt to refute them. In a second letter Vernon Coleman asserts that "animal experiments are so misleading as to be dangerous."[5] He must surely remember that a good deal of the physiology and pathophysiology he learnt is relevant to modern drug discovery, yet he continues to perpetuate the myth that animal experiments have done nothing to help us combat disease.[6] I am sure everyone reading this will immediately think of multiple exceptions to this sweeping generalisation.

It is worth looking at the question Coleman asked in his survey.[5] It was couched in such a way that most doctors would be obliged to agree. It is time that medical researchers set about telling the public what they are doing.

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Exiled from the Dream Time

SIR,—I cannot agree with Patricia Morison that the debate about restitution of Aboriginal remains is complex.[1] As medical officer for the Victorian Aboriginal Health Service. I believe that the BMA should add its voice to that of those who are trying to persuade London's Natural History Museum and other institutions to return Aboriginal remains to Australia.

These human remains are often not from aeons past but are those of the relatives of some of my patients and their kin. The dead, and their places of burial, hold great spiritual significance for Aboriginal people, who are deeply disturbed by the knowledge that remains of their ancestors have been removed to Britain. Morison suggests that the fact that bodies were procured illegally is "a red herring" and that the possibility that they may be used for scientific research justifies their retention. Under British law, however, a claim to be making good use of stolen goods does not allow the receiver to keep them. None of the Aboriginal specimens in British institutions were obtained with the permission of the subjects or their relatives: at best they were removed from graves "uncovered by erosion or development," at worst they were obtained by murder.

The medical profession was concerned in the removal of these bodies and, I believe, has a duty to call for their return.

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